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Health Planning

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American Health Planning Association

President's Message – Fall 2005

Health System Trends

by Dean Montgomery

Two recently released reports, the Kaiser Family Foundation (KFF) annual survey of employers and the Center for Studying Health System Change (CSHSC) biennial survey of 12 health care markets nationwide, provide glimpses of the health system changes now underway and hint at the longer term implications of these practices and trends.

KFF reports that *average* family health insurance premiums reached \$10,880 in 2005. With average costs approaching \$11,000 a year, nearly equal to annual full-time minimum wage earnings, larger numbers of employers, particularly smaller firms, are being priced out of the market. In 2005, only 60% of employers provide coverage, down from 69% in 2000, a decrease of 13%. Less than half of firms with fewer than 10 employees offer health insurance.

Although large companies generally provide coverage, with 98% of those with more than 200 employees offering coverage of some type, the breadth and scope of coverage is shrinking. Many insurers and employers are promoting so-called "consumer driven" insurance plans, with their high deductibles and co-payments, as alternatives to higher cost standard coverage. Where there is work-based coverage, the employer pays, on

Cont'd. on page 2

Inside this Issue . . .

- Health System Trends
- MRI Survey Data Suggests "Capacity Matters"
- Policy Perspective: Planning Cardiovascular Services
- Universal Health Care
- American Public Health Assoc. Conf.: AHPA Sessions
- Check it Out! Bright New Face to AHPA Website

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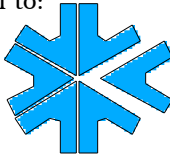
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Information for the quarterly journal is due on March 1, June 1, September 1, and **December 1**. Articles should be short — no more than one page of text. The Editor reserves the right to edit any article or submission, as needed.

Information may be submitted via e-mail to:

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Margaret King, Editor



Health System Trends Cont'd. from page 1:

average, about three-fourths (74%) of the premium. CHSC has been following health system developments for more than a decade using biennial surveys of health system officials in a dozen health care markets nationwide. The 2005 survey is the fifth conducted by the Center. Recent survey results reinforce and amplify earlier observations. Key findings include:

- ❖ Despite excess capacity in many communities, the building boom that began in the late 1990s continues in both inpatient and outpatient facilities. Tens of billions of dollars continue to be invested annually in facility modernization and expansion. Beyond routine replacement and modernization of outdated facilities, the capital spending and investment is disproportionately for profitable specialty service development in affluent, well-insured communities. Flight from less affluent, poorly-insured communities continues.
- ❖ Competition for profitable patients among hospitals, and between hospitals and physicians, fuels much of the system change and spending underway. The focus is on selected profitable services: cardiology, orthopedics,

oncology, outpatient surgery, and diagnostic imaging.

- ❖ Socially nonproductive competition between and among hospitals, freestanding service centers, and physicians appears to be having significant system distorting effects. It contributes to decreased average service volumes, reduced system efficiency, and increased withdrawal of operating returns as profit, promotes undesirable joint ventures, and provides economic incentives for the provision of unnecessary services and of care of little benefit to patients.
- ❖ With the possibility of shifting their practices, or selected patients, to outpatient services in which they may have a financial interest, larger numbers of physicians are shunning hospital and related professional community service. Many hospitals are being forced to hire physicians to provide on-call emergency, trauma and specialty care – inpatient psychiatric services for example – for some patients is growing.
- ❖ With the shift of profitable services to physician-owned facilities, and the increased focus on profitable services at some hospitals, “safety net” community hospitals are under increasing pressure to provide needed, but unprofitable, services. The revenue stream needed to support these services is drying up.
- ❖ Other than increased cost sharing and market segmentation strategies, few cost control strategies have emerged. Managed care use of controls and selective provider contracting have fallen into disfavor, and the much touted “consumer driven” insurance products (e.g., high deductible coverage, health savings accounts, health reimbursement accounts, tiered networks) have shown little promise to date.

Overall, health system trends have been increasingly problematic over the last decade. Insurance coverage is decreasing, cost increases continue to outpace wages, economic growth, and inflation, access is becoming more restricted, profiteering is becoming ingrained in some sectors, quality remains uneven, and doctrinaire reliance on market forces to establish access, quality and cost levels is approaching 19th century currency. Prospects for improvement soon are not evident.

Planners need to be familiar with, and wary of, these developments. Where possible, they should be taken into consideration in planning and regulatory processes and decisions. 🍏

MRI Survey Data Suggests “Capacity Matters”

Arthur Streeter, Assistant Director
Finger Lakes Health Systems Agency

It’s nice when data comes along that affirms a principle of one’s belief system. Most health care planners probably believe in Roemer’s Law, which is usually presented as “A bed built is a bed filled”. A newer version is “If you build it they will come.” Wennberg’s work on small area analysis also tends to support this tenet. Rarely, though, is data put together which demonstrates Roemer; aside from Roemer’s original work, most planners take it on faith that, in health care, it is true.

The Finger Lakes Health Systems Agency (FLHSA), a long-standing planning agency in Upstate New York, recently had a chance to test Roemer and Wennberg’s theories. Under the auspice of Excellus/Blue Cross Blue Shield, FLHSA gathered data on the inventory of high tech equipment, such as MRI and PET scanners, in the Upstate service area, along with utilization data. Data was obtained by mail and telephone survey from both hospital-based (CON-approved) and physician-owned (outside CON) services. The response rate was around 90% for most of the services, but collateral sources were used when available for non-respondents.

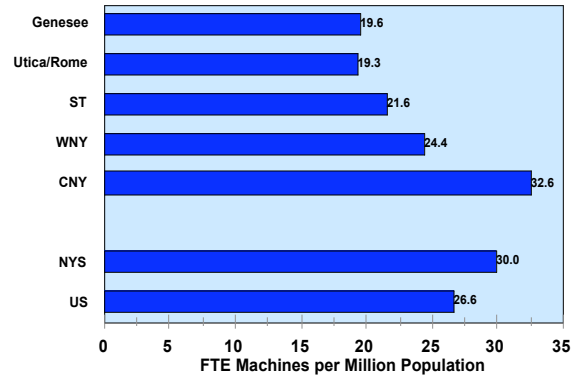
The survey data strongly suggests that capacity matters in explaining variations in utilization rates from place to place. Consider the figure on MRI capacity and utilization. There is a clear correlation between capacity per population and utilization per population.

Not every service has as clear a relationship as MRI. PET scanning, for instance, clearly reflects insurance company demand management techniques (e.g., pre-authorization) rather than capacity. CT scanning reflects a more mature medical sense of the clinical indications.

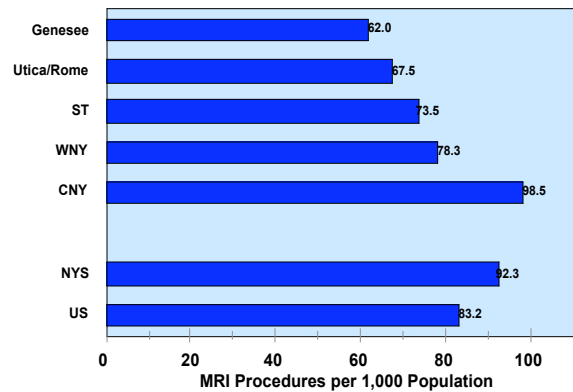
Does having more capacity matter? There are those who would argue, for instance, that the cost of an empty bed is minimal, in that empty beds are not staffed and capital costs are essentially sunk costs. This data indicates that utilization increases with increased capacity. Further, while the linkage is indirect, the upstate markets with more capacity tend to also have higher insurance rates.

A market-oriented philosophy would suggest that imbalances in supply versus demand for health

MRI Machines per 1,000,000 Population
Upstate NY Regions & Comparison Areas



MRI Utilization per 1,000 Population
Upstate NY Regions & Comparison Areas



Regional Data Collected by Finger Lakes Health Systems Agency March to June 2004
National and New York State Data from IMV Medical Information Division, Inc., 2005.

care would be resolved over time. In other words, excess capacity would be eliminated by the market place, and the system would “right size.” However, there are many classical economic assumptions about markets, such as consumers being price conscious, which do not fit the health care market. Questions must be raised, then, about whether “the market” can be expected to provide the needed influences to eliminate any excess capacity or provide services to hard-to-serve populations. It is important to provide “extra-market” forces – capacity management – to assure that there is a balance between the public’s need for health care services and the supply to meet those needs.

The full reports on the capacity study can be downloaded from the FLHSA website at flhsa.org under Publications, including a chart book under Major Publications entitled “Capacity and Use of High Tech Medical Services in Upstate New York” and a white paper on “Capacity Matters” under Health Matters. 🍎

Policy Perspective Planning Cardiovascular Services

by John Steen, Consultant, Health Planning and Health Policy

In my column in the previous newsletter, I reported that a committee of the Pennsylvania state legislature had issued a report critical of the Department of Health's (DOH's) pilot two-year demonstration project in which 11 hospitals without open heart surgical capability had been granted a waiver from licensure requirements in order to permit them to perform non-emergent percutaneous coronary intervention (PCI). It found that in these hospitals, elective therapeutic cardiac catheterizations were being done contrary to national quality benchmarks and against American College of Cardiology (ACC) guidelines. Its criticisms have revived the question of how the state should be regulating health care in a post-certificate of need (CON) era. The state permitted its CON program to expire in 1996, and has been relying on its licensure process to regulate over the past nine years.

This report reflects a growing realization by legislators that the state has lost its ability to adequately regulate the proliferation of specialized, high-profit clinical procedures, chief among them CABG (23 new programs have been established since 1996) and PCI, and that it has lost its control of quality and cost issues in general. In its discussions preceding the report, consideration was given to restoring health facility performance standards, including proficiency volume, as conditions of licensure. Among the report's findings was that one-third of Pennsylvania's open heart surgery programs have volumes below proficiency standards being used by other states, and that some of them have mortality rates exceeding national benchmarks.

Its review of PCI outcomes reports the following relation between volume and mortality:

<u>Facility PCI Annual Volume</u>	<u>Observed Mortality Rate (in hospital)</u>
>400	1.35%
<400	1.41%
<200	1.46%
<100	1.73%

Legislation introduced in the Pennsylvania General Assembly would require the DOH to form a cardiac oversight committee working with the ACC's Pennsylvania Chapter, to develop clinical guidelines to inform hospital regulations, develop performance criteria – including complication rates and mortality and proficiency volumes – for highly-specialized cardiac services, and develop guidelines for peer review. This is a process that New York State has been using effectively since the era of health planning in the 1960s. The DOH once had a Cardiac Catheterization Oversight Committee and as recently as 1995 when CON criteria applied to PCI volume, the DOH convened the committee to review hospitals that were performing low volumes of diagnostic and therapeutic catheterizations. In undertaking its PCI initiative, the DOH failed to respond to offers from the ACC to provide its expert assistance in overseeing results. The legislature noted that New York also requires a minimum annual volume of 400 procedures, and it achieves a mortality rate that is only one-half that of Pennsylvania.

The American College of Cardiology and American Heart Association guidelines currently say elective angioplasty should not be performed in hospitals without the ability to perform cardiac surgery, but the Johns Hopkins School of Medicine

Cont'd. on page 5

Policy Perspective

Policy Perspective
Cont'd. from page 4:

has just launched a national three-year clinical trial study of more than 16,000 patients to better determine the safety and efficacy of angioplasty in non-emergency situations. About 40 community hospitals are expected to participate in the study. Special waivers from state authorities are required for participating community hospitals. In addition to the waiver from their state government, participating community hospitals must also have a combined emergency and elective angioplasty volume of at least 200 cases per year and a staff whose training meets national standards set by the American Heart Association and American College of Cardiology. States that have been asked to participate include Alabama, Georgia, Illinois, New Jersey, Ohio, Pennsylvania, Maryland, and Washington. Officials of the first six states listed have already granted the waivers. Funding for the study is provided by participating hospitals. For an account of this, see:

http://www.bizjournals.com/industries/health_care/hospitals/2005/09/05/baltimore_story3.html.

Upon the legislature's recommendation, the DOH has agreed to make participation in a national clinical trial a condition of renewal for all waiver sites, and will seek to enter them in the Johns Hopkins national trial.

In its response to the legislature, the DOH noted the legislature's failure to restore CON in the state while using the CON model in criticism of DOH regulation, stating that **the validity of such a policy framework has been seriously questioned by the U.S. Department of Justice and the World Health Organization.**

Calling CON "a set of non-marketplace supply restriction regulations and a highly complex quantitative analysis of outcome benchmarks," DOH stated that with the demise of CON, it had lost any statutory authority to establish or enforce quality benchmarks, and current regulations do not have explicit facility performance requirements. DOH is currently working under hospital licensure regulations that are over 20 years old. Though the legislature is no longer entertaining the restoration of CON in Pennsylvania, it is considering legislation to expand the DOH's authority to regulate using quality and safety standards for licensure. Under CON, criteria for

quality were established legislatively, but it is now proposing the establishment of a clinical advisory committee that would develop the quality indicators and analyze performance data, conduct clinical peer review and recommend licensure actions against a hospital that failed to meet key quality indicators and correct deficiencies.

In August, DOH released a draft version of its health care facility regulations for comment, including:

- ◆ A new licensure category, which defines *outpatient ambulatory health care facility* as providing emergency services, cardiac catheterization services, cancer treatment services involving radiation therapy, imaging services, pain management services, burn center services, and ambulatory surgery services;
- ◆ Minimum charity care levels and limitations on collection practices for hospitals and outpatient ambulatory care facilities;
- ◆ Minimum nurse staffing ratios for critical care, intensive care, coronary care, and neonatal intensive care units, and requirements to report nurse staffing ratios for each patient care unit of a hospital or outpatient ambulatory care facility; and
- ◆ A requirement for any publicly-traded company to obtain DOH approval prior to operating a health care facility.

State regulators are properly concerned about maintaining the highest volumes feasible under the circumstances for all specialized medical procedures requiring special skills. Evidence of the efficacy of this continues to grow, and a new study reported in the September 1, 2005 issue of *Cancer*, the peer-reviewed journal of the American Cancer Society, indicates that post-operative mortality and complications for cystectomy – the surgical removal of the urinary bladder – were reduced by up to 75 percent in the best-case scenarios. Mortality was higher in low-volume hospitals compared with high-volume hospitals (3.1% vs. 0.7%; $P < 0.001$). Investigators led by Linda S. Elting, Dr.P.H. of the University of Texas M. D. Anderson Cancer Center in Houston, collected and analyzed data from 1,302 bladder cancer

Cont'd. on page 9

Universal Health Care

By John Steen, Consultant in Health Planning,
Health Regulation, and Public Health

The last attempt to formulate a national plan for universal health care ended 11 years ago with the collapse of the Clinton Plan for “health care reform.” Since then, there have been incremental initiatives toward greater health care coverage, notably HIPAA and SCHIP, but as laboratories for developing universal health care, the states have not been able to marshal the necessary political and economic resources. This may now be changing. According to the National Conference of State Legislatures, at least 18 states currently have introduced legislation regarding universal health care: California, Colorado, Connecticut, Florida, Hawaii, Kansas, Illinois, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, and Vermont.

Maine

Maine’s Dirigo Health plan has gotten considerable attention since it was signed into law in 2003. It is a voluntary, market-based plan, intended to achieve universal coverage in the state by 2009. It was designed to provide small businesses and employees with an option for coverage. But as a voluntary plan, it will fall far short of universal coverage, for it uses private marketplace health insurance, with premiums subsidized by the state on a sliding scale based on family income. Maine contracts with Anthem Blue Cross and Blue Shield of Maine and competes with existing health plans to offer health coverage to employees who work at least 20 hours per week. Employers must offer coverage to dependents and families. Employers cover at least 60 percent of the cost of the workers’ premiums, and employees must then pay the remainder of the cost. The state now provides coverage for families earning up to 300 percent of the federal poverty level. Maine has about 138,000 uninsured citizens to cover. Officials have yet to resolve several funding issues, including how to redirect anticipated savings for insurers.

Vermont

On April 21, the Vermont House passed and sent to the Senate a bill to create a single-payer system under which all Vermonters would gain coverage for all health services determined to be “essential” by the state government. It would create a health care delivery system that is “equitable, universal, well-coordinated, patient-centered, cohesive, unified, comprehensive, continuous, sufficient,

fair, sustainable, and accountable,” establish cost containment targets, and enforce them through global budgets for hospitals and caps on physician reimbursement rates. The state would impose “play or pay” taxes on both employer payrolls and employee paychecks at businesses that don’t offer health insurance. State health planning would be brought back in the form of an “integrated, community-based system” overseen by regional community health boards composed of citizens. The cost to the state would be about \$2 billion per year, but it could save Vermonters more than \$118 million a year over current medical insurance costs and cover every Vermonter in the process, according to a study by the Lewin Group.⁽¹⁾ Of course, if enacted, the funding available to the state legislators will help them decide what services are “essential.” The legislation does not address how to integrate Medicare, Medicaid and other public health insurance programs into the state’s universal health care. On June 22, Governor Jim Douglas (R) vetoed it. His administration is working on a new proposal, and the state legislature has created a 10-member panel to explore reform options.

California

Remember the old saw about California, “Whatever is going to happen, will happen first in California?” That most populous of our states has been leading the way in many national trends for a long time now, so one wonders if it could now be a harbinger of the beginning of the first true universal health care system for the nation. California has been considering a much more radical approach, one that would use a single-payer to achieve true universal health insurance. Senator Sheila Kuehl (D-Santa Monica) is sponsoring legislation, dubbed the California Health Insurance Reliability Act (SB 840) that would provide medical, dental, vision, hospitalization, and prescription drug benefits for all Californians. It would replace private insurance plans and also extend coverage to approximately 7 million Californians who have no health insurance. The program would be funded by a system of means-based premiums, and all uninsured residents would have to buy coverage or enroll in a sponsored program. A Lewin Group study (“The Health Care for All Californians Act: Cost and Economic Impacts Analysis,” January 19, 2005) found that a single-payer system could cut health care expenses in California by \$25 billion per year, and save California \$343.6 billion in health care costs over the next 10 years, mainly by cutting administration costs and using bulk purchases

Cont’d. on page 7

*Universal Health Care
Cont'd. from page 6*

of drugs and medical equipment. The bill passed the Senate in June, and now it is to be considered by the House. A companion bill to spell out financing is to be introduced in 2006.

Under this plan, the state's residents would pay for their health care through their taxes instead of paying insurance premiums, and health insurance would no longer be sold in the state. That alone would excise an enormous cost from the state's health care burden. As for hospitals and other providers, they would once again be paid under fee-for-service, an arrangement they should like better than being subject to so many administratively differing health plans. The efficiency of having just one system with greatly reduced administrative costs (planning replaces marketing) and tremendous purchasing power over pharmaceuticals, medical devices, supplies, and equipment, would result in an affordable system covering everyone. Of course, its ability to truly cover everyone, and its ability to expend its resources on prevention and public health rather than on the profit motive, is what inspires those of us who still have the public interest at heart, and see health care as a right. In this view, it is fitting that individual means should be translated into the public purchasing power that can work for the public good, but that good will only be realized if legislators' oversight of all the program's parameters provides for continued commitment to those principles under which the program was originally established.

There have been parallels between California and the nation in this for at least sixty years. At about the time that President Truman was proposing to establish a national health care system in 1948, an idea shot down by the American Medical Association, American Hospital Association, and Senator Taft of Ohio among others, then Republican Governor (and later Chief Justice of the U.S. Supreme Court) Earl Warren was proposing it in California.

Perennial Problems: One Solution

The fundamental problem in the states is that they contain within them the same competing interests that doomed the Clinton plan, and so a greater counter-vailing force from outside the states is needed. In a nation where business prosperity is paramount and competition is respected and feared, the decisive push to do something may be found in what it will take for businesses and states to prosper today. General Motors and the other automakers are a case in point for the inability of business to

continue to bear the burden of health insurance benefits and compete in a multi-national marketplace. Wal-Mart, and other low-wage employers that fail to provide full health insurance to many of their employees, have raised issues of unfair competition by shifting their costs to the states through the states' safety net programs. At the same time, the states are so short of revenue for continued funding of Medicaid and other programs in their budgets, that they are looking to tax their businesses for increased revenue. In addition, the states are facing rapidly rising costs for the health benefits they continue to provide to their own former employees in retirement.

While advancing these ideas, it must also be admitted that government-run programs are always subject to all the pitfalls of politics and the wastefulness of bureaucracies. We must be willing to countenance replacing marketplace competition with political policymaking. We must believe in our ability to achieve equity in health care through good public process. As Americans, we must re-educate ourselves to participate as well-informed citizens in a national debate over health care budgeting and rationing. The degree of social justice present in a national health care system is largely a question of how progressive the tax system is that supports it. Like all government, this too must be government by the people and for the people. That means that it will work only so long as the people's eternal vigilance provides the accountability to make government service a moral imperative. In an era when "public" has been denigrated and "private" oversold, and taxes abhorred in favor of paying even more out of individual motivation and discretion, it will be easy for conservatives and the private sector to instill fear in voters just as they did with the Clinton Plan in 1994, and also with still another single-payer legislative initiative that failed in California at the same time.

Can there be any solution to this short of a federal takeover of the financing of health care? With its own rapidly growing costs for an expanded Medicare program and well over half the costs of Medicaid, how else but by realizing the administrative efficiencies of a single-payer health care system can the federal government accomplish it? By consolidating federal, state, and private health insurance programs under one administration, the savings could be more than sufficient to fund a true universal health care program.⁽²⁾

Cont'd. on page 8

Universal Health Care
Cont'd. from page 7

Computing Cost Savings/ Affordability

The National Coalition on Health Care (NCHC) has studied various scenarios for providing universal health care, and has intensively analyzed four of them:

1. Employer mandate supplemented by individual mandates where necessary;
2. Expansion of existing programs that currently provide coverage to defined populations;
3. Development of a new program modeled after the Federal Employees Health Benefit Program (FEHBP); and
4. A universal, publicly-financed, single-payer program.

All four approaches to universal health care would result in overall cost savings nationally out of the same efficiencies California wishes to realize. The NCHC employed Professor Kenneth Thorpe of Emory University to compute the savings that would be projected to accrue from operationalizing each plan. Thorpe projected that the cost savings in each plan's tenth year (2015) would range from \$125 billion to \$182 billion. He also made projections for the total change in spending (i.e., the cumulative savings) for each in comparison with the nation's present "system" for the years 2006 through 2015, and came up with the following figures:

1. \$320 billion reduction;
2. \$320 billion reduction;
3. \$370 billion reduction; and
4. \$1,136 billion (\$1.136 trillion) reduction.

These net savings accrue even after taking into account the increases in federal spending needed to secure universal coverage. The report⁽³⁾ summarizes the impact of these plans on national health care spending as follows:

System-wide health care reform, along the lines that the Coalition's specifications envision, would produce substantial reductions in national health care spending - reductions that would begin soon after reforms were phased in and that would increase over time.

As projected by the Centers for Medicare and Medicaid Services (CMS), national health care spending would be expected to rise under

current law - that is, in the absence of major health care reform - from nearly \$2.1 trillion in 2006 to more than \$3.8 trillion in 2015. That means that the proportion of our gross domestic product devoted to health care spending would jump from about 15.6 percent now to 19 percent in 2015 - an increase of 3.4 percentage points. (p.12).

Public Health vs. the Profit Motive

Some of us see all four of these approaches as incremental too, for they address the financing of health care, but do nothing to rationalize its delivery. To do that, further steps are needed to remove the remaining profit motive from the delivery system and restructure its priorities toward prevention and public health. Only then might we as citizens and taxpayers receive full value for what we spend on health, a measure in which we ranked 72nd among all nations in the *World Health Report 2000*.⁽⁴⁾

Universal Health Care can be more than just efficient in its use of public resources. It can serve the greatest good by taking two more radical steps.

- Adopting a public health model for its goals and priorities; and
- Eliminating the profit motive from health care.

Making public health a national priority means empowering communities to support the best possible health status for everyone in them. This gives us a set of imperatives sorely missing from today's health care: To provide health education as a fundamental part of everyone's right to public education so that they may become promoters of their own wellness; to foster health promotion, primary care, and disease prevention; and to enable all community members to understand and participate in public forums on health policy.

The principles of compassion, fairness, and social justice that define public health are incompatible with the profit motive in health care. Rather, the resources taken out of the community to fund health care should be returned as benefits to the community. Thus, we can see the second step as implicit in the first.

Of course, what we are proposing here is what is appropriately labeled "socialized medicine," and the connotations of the term presage its fate in

Cont'd. on page 9

Universal Health Care Cont'd. from page 8

our nation. In the only example available to us out of American experience, it would be like expanding the Veteran's Administration health care system (a true system!) to cover *everyone*, and making all health care providers salaried employees of the U.S. Public Health Service, resulting in a system like that of the U.K. (1946). The government ownership of the health care delivery system would be more "socialization" than would be palatable to a people wedded to ideals of opportunity through entrepreneurship and through unlimited personal spending for one's own health care. Therefore, progressive policy advocates use Medicare as a model instead, proposing to stretch its reach to cover all ages, thereby preserving the beloved private practice model, and resulting in a national system like that of Canada (1966).⁽⁵⁾

Will California lead the way in revealing to us that "Health Care Is a Right" and that it requires us to finally develop a national health care delivery system? If so, how radical a system? History teaches us that countries have systems reflecting their own established values and precedents. The democratic process in which political and business interests are already entrenched is surely one of ours. Opposition to radical economic, political, and social change is overwhelming, and so change is evolutionary, not revolutionary. We may yet wind up extending Medicare incrementally to ever younger ages, but let us always do so with a vision of these ideals present in mind and heart. The answers to such questions are yet to come, but I believe that they must come through a campaign that has the quality that William James described as "the moral equivalent of war."

References

- (1) "Analysis of the Costs and Impact of Universal Health Care Coverage Under a Single Payer Model for the State of Vermont," The Lewin Group, Inc., August 28, 2001. Full text of the study is available on-line at:
[http://www.dsw.state.vt.us/districts/ovha/Analysis of theCosts.pdf](http://www.dsw.state.vt.us/districts/ovha/Analysis%20of%20the%20Costs.pdf).
- (2) Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med* 2003; 349:768-775.
- (3) For Thorpe's report, go to
<http://www.nchc.org/materials/studies/Thorpe%20booklet.pdf>.
- (4) For a useful summary of the World Health Report 2000 and its insights for the US health care non-system, see "With Liberty and Justice for All?"
- (5) Jon Oberlander, associate professor of social medicine at the University of North Carolina at Chapel Hill, has argued that, "in the United States, the more desirable health care reform is on substantive grounds, the less politically feasible it is." For further background on these issues, see his, "The Politics of Health Reform: Why Do Bad Things Happen to Good Plans?" *Health Affairs*, 10.1377/hlthaff.w3.391 (August 27, 2003).

Accessible at:

<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.391v1>. Oberlander writes: "Here is the ultimate paradox of U.S. health politics: Rising health costs put health care reform on the agenda, but the more likely a reform proposal is to control costs, the less likely it is to be politically viable." 🍎

Policy Perspective Cont'd. from page 5:

patients who underwent cystectomy between January 1, 1999 and December 31, 2001, in all 133 Texas hospitals. They found about 12 percent had post-operative complications and about 2.2 percent died. But hospitals performing over 10 cystectomies per year had statistically significant lower mortality and morbidity rates. Mortality was reduced by almost 75 percent and complications were reduced by approximately 50 percent at the high-volume hospitals. **Interestingly, hospitals with a high registered nurse-to-patient ratio reduced post-operative mortality by more than 50 percent regardless of the hospital's cystectomy volume.**

To see the article, "Correlation between annual volume of cystectomy, professional staffing, and outcomes: A statewide, population-based study," go to:
<http://www3.interscience.wiley.com/cgi-bin/abstract/110552670/ABSTRACT>. 🍎

American Public Health Association Conference AHPA Sessions

The following sessions are being sponsored by the American Health Planning Association as invited sessions by the APHA Community Health Planning and Policy Development Section (*time and locations are subject to change because of relocation, check the AHPA website for details.*)

3181.0: Monday, December 12, 2005: 12:30 PM-2:00 PM **Evidenced Based Planning: Theory vs Practice**

ABSTRACT: There is general agreement among planners and health service developers that evidence-based policies and practices should be followed where and when possible. The advantages of clearly stated principles and policies, grounded in proven results and measurable outcomes, are numerous and manifest. Problems arise in trying to translate theory into practice, however. Difficulties encountered include: the ambiguity of what constitutes evidence; a paucity of service-specific standards; and limited reliable data and information to document and measure results. This presentation explores the opportunities and challenges in establishing and applying evidence-based principles and standards.

Topics and questions to be explored include: what constitutes "evidence" in evidence-based planning; data and information requirements; and essential elements and structure required for successful evidence-based planning and service delivery. Attendees should gain a better understanding of the potential value of broader application of evidence-based principles and planning, the inherent difficulties of establishing and maintaining evidence-based practices, the information and other resources needed to permit evidence-based planning and service development, and the problematic role of social science research in identifying and measuring evidence and outcomes.

Organizer and Moderator: Dean Montgomery, MA, MSPH

Evidenced Based Planning: Theory vs Practice

Dean Montgomery, MA, MSPH

Evidence Based Planning: Principles, Policy, and Ethics

John W. Steen, PhD

Knowledge-based Quality: Using Information and Evidence in Practice

Robert R. Vogel, MPA

Using Evidence in Structuring and Evaluating Two Diverse Approaches to Improving HealthCare

Paul Parker, MPH

For more information, go to http://apha.confex.com/apha/133am/techprogram/session_16371.htm

3360.0: Monday, December 12, 2005: 4:30 PM-6:00 PM **Certificate of Need Challenges:** **Improving Quality, Meeting Needs and Assuring Access**

ABSTRACT: This session consists of a panel of three active health care leaders representing states with comprehensive certificate of need (CON) programs. The format is three 15-minute presentations of individual perceptions and experiences, followed by an extensive interactive

Cont'd. on page 11

AHPA Sessions
Cont'd. from page 10

debate and audience participation. The presenters will draw upon years of experience and assessment of CON programs around the United States, plus information from numerous studies and surveys.

With 36 states (plus the District of Columbia) administering CON programs, the impact of CON effectively cuts across many sectors of our health care industry. The first session will address health care quality and the many ways in which effective regulation can impact various dimensions in health care delivery. The second session will address public need and the important methodologies used to assess the supply and demand of current and future health care system growth. The third session will address access for public and private health services, in institutional and outpatient settings in terms of geography, economy, culture and many other factors.

Organizer: Michael K. Dexter, MPA
Moderator: Thomas R. Piper, BArch

Certificate of Need Challenges: Improving Quality

Michael K. Dexter, MPA

Certificate of Need Challenges: Meeting Community Needs

Thomas R. Piper, BArch

Certificate of Need Challenges: Assuring Access

Sonya R. Albury, MSW

For more information, go to http://apha.confex.com/apha/133am/techprogram/session_16358.htm.

4116.0: Tuesday, December 13, 2005: 12:30 PM-2:00 PM
**Community Based Chronic Care Services: A Planning and Implementation Model
for Evidence Based Improvements at Community and Practice Settings**

ABSTRACT: The Public Health Resource Group (PHRG), Eastern Maine Healthcare Systems and others in consultation with the World Health Organization (Health System Policies and Operations) have been developing and testing innovative approaches to planning and implementing evidenced based chronic care improvements. These approaches are being used and validated in different settings and countries. Grounded in WHO's Innovative Care for Chronic Conditions (ICCC) framework and building blocks we has developed, tested and implemented a chronic care planning and implementation roadmap and system that identifies community chronic care needs and issues, employs best practice processes to implementing evidence based change and evaluates and monitors change with process and outcomes measures for practices and patients.

There are several components that are key to this system including rapid assessment tools that a) identify population chronic care conditions for prioritizing need, b) assess community based resources for patient self management and their linkages to primary care providers, c) assess the status of community level policies for their contribution to chronic disease; d) determine the level of practice infrastructure and operational readiness for best practice improvements, e) evaluate practices in the management of chronic conditions to evidence based guidelines and care and, f) determine patient barriers to care. To date preliminary rapid assessment tools have been develop and tested for a, b, d, and e. Additional components include a change process adapted from the Institute for Healthcare Improvement's (IHI) Breakthrough Collaborative Series, and a framework for monitoring and evaluating changes.

Cont'd. on page 12

AHPA Sessions

Cont'd. from page 11

Organizer and Moderator: Ronald D. Deprez, PhD, MPH

Chronic Care Service Improvement: Planning and Implementing

Evidence Practice Improvements for COPD patients in rural communities

Jean Mellett, MBA, Ronald D. Deprez, PhD, MPH, James Haley, MD, MBA, CPE,
John Branscombe, MSB, Gregory Merriman, MPH

Innovative Care for Chronic Condition (ICCC):

A Global Approach to Improving Chronic Care Services

Alberto Barcelo, Dr, Raphael Bengoa, PhD, Ronald D. Deprez, PhD, MPH

Community Based Planning using the ICC Model:

Essential Tools for Evidence Based Chronic Care Planning

Ronald D. Deprez, PhD, MPH, William B. Stason, MD,
Lisa Sockabasin, MPH, Leanne Marcotrigiano

For more information, go to http://apha.confex.com/apha/133am/techprogram/session_16358.htm.

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